VERMONT

Department of Vermont Health Access
NOB 1 South, 280 State Drive
Waterbury, Vermont 05671-1010

~General~

Prior Authorization Request Form

In order for beneficiaries to receive Medicaid coverage for medications that require prior authorization, the prescriber must telephone or complete and fax this form to Change Healthcare. Please complete this form in its entirety and sign and date below. Incomplete requests will be returned for additional information. For questions, please contact the Change Healthcare helpdesk at 1-844-679-5363.

Submit request via Fax: 1-844-679-5366

Prescribing physician:
Name: _____
Physician NPI: _____
Specialty:_____
Phone#:_____
Fax#: _____
Address: _____
Contact Person at Office: _____

Beneficiary:
Name: _____
Medicaid ID#:_____
Date of Birth: _____ Sex: _____
Pharmacy Name_____
Pharmacy NPI: _____
Pharmacy Phone: _____Pharmacy Fax: _____

The following MUST be completed for MEDICAL BENEFIT requests:

- HCPCS J-code or other code:_____
- Administering Provider/Facility: Name_____ NPI#_____ Medicaid ID#_____

Please **check box** if this drug is being provided under the DVHA's 340B Drug program and requires the **UD modifier** ☐

1. Drug Requested:_____

   Strength/Route/Frequency:_____ Length of Therapy:_____

2. Patients diagnosis for use of this medication:_____

3. Previous history of a medical condition, allergies or other pertinent medical information, that necessitates the use of this medication:_____

4. Was patient seen by any other provider for this condition? YES/ NO What specialty? _____

5. Please list preferred medications previously tried and failed for this condition (clinical notes or other records may be requested if medication trials cannot be located in the member's claims history):

Name of medication	Reason for failure	Date
_____	_____	_____
_____	_____	_____
_____	_____	_____

6. Please list pertinent laboratory test(s) or procedure(s) if applicable:

Procedure	Finding	Date
_____	_____	_____

7. Other Information/ Comments:_____
   _____

By completing this form, I hereby certify that the above request is true, accurate and complete. That the request is medically necessary, does not exceed the medical needs of the member, and is clinically supported in your medical records. I also understand that any misrepresentations or concealment of any information requested in the prior authorization request may subject me to audit and recoupment.

Prescribers Signature: Date:

CHANGE HEALTHCARE™